

Lifestyle & Health Intake Form

Name: _____ Age: _____ City: _____ Referred by: _____ # of children: _____

The Purpose or reason for this appointment?

Has this issue altered your Quality of Life? _____ How long have you had this issue? _____

Have you had Chiropractic ever? _____ Who? _____ When was the last time? _____

When was your last physical exam? _____ Who is your primary care physician? _____

Is this issue related to an auto or work accident? _____ Do you work in front of a computer most days? _____

How is your typical diet/Food? _____ Pop? _____ Alcohol? _____ Coffee? _____ Cigarettes? _____

How much pure water? _____ Exercise? _____ How often? _____ Hours of Sleep? _____

Are you happy with your overall health? _____ Do you put much thought into your health/diet? _____ Do you eat breakfast? _____

Do you crave certain foods? _____ /What? _____ How much time do you commit to you and your health and mental well-being daily? _____ How long has it been since you really felt good? _____

What your stress level? 1 (low)- 10 (maxed out)? _____ What is your main source of stress? _____

Medications List: Please name your prescription or over-the-counter medications/
vitamins: _____

Conditions: Please circle any of the following symptoms which you now have or have had in the past.

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|-----------------------|----------------------------|-------------------------|
| Allergies | Dizziness | Menopausal problems |
| Anger/ rage problems | Ear problems | Mid back pain |
| Anxiety | Eye conditions | Neck pain |
| Arthritis | Fatigue/ low energy levels | Numbness |
| Bedwetting | Gall bladder problems | Pacemaker |
| Bladder control | Gastro-intestinal problems | Prostate problems |
| Bloating or gas | Headaches | Shoulder pain |
| Brain fog | Heart problems | Sinus infection |
| Cancer | High/low blood pressure | Skin conditions/ rashes |
| Chest pain | Hormonal problems | Sleeping difficulties |
| Cholesterol problems | Infertility | Stroke |
| Chronic cough | Kidney infections | Sweaty palms/ feet |
| Constipation | Kidney stones | Thyroid issues |
| Cramps/ muscle spasms | Knee pain | Weight gain/loss |
| Depression | Low back pain | Yeast issues |
| Diabetes | Lung conditions | |

In what ways are you wanting us to help you and your health concerns? _____

Is there a **specific treatment** that you know you are looking for? _____ If so what? _____